

4.SPECIFICATIONS

The State of Kansas is issuing this Request for Proposal to obtain competitive responses from vendors to provide Recovery Audit Contractor (RAC) services and Health Care Cost Containment and Recovery Services per the attached specifications, for the Kansas Health Policy Authority (KHPA), Topeka, KS.

4.1 Term of Contract: The term of this contract is for an initial three (3) year period from the Date of Award (DOA) of this RFP with the option of three (3) additional one (1) year renewals by mutual agreement of both parties.

4.2 Background.

KHPA is the single state agency responsible for developing and coordinating health policy in the State of Kansas. KHPA is directed by a nine (9) member citizen board as well as six (6) non-voting ex-officio members that include state agency secretaries. KHPA is the single state Medicaid agency and also administers the State of Kansas's Children's Health Insurance Program (CHIP) and the State Employee Health Benefit Plan. The agency was created in statute by the 2005 legislature. Prior to this date, Medicaid and CHIP were functions of the Department of Social and Rehabilitation Services (SRS) which continues to serve as the umbrella agency for most Social Service programs, including Temporary Assistance for Needy Families (TANF), and Child Welfare services.

The Kansas State Legislature in the 2010 legislative session passed legislation (House Substitute for Senate bill 572, signed by the Governor on May 27, 2010) directing the Kansas Health Policy Authority establish a pilot project for Health Care Cost Containment and Recovery Services to be implemented regarding programs of state agencies or programs responsible for payment of medical or pharmacy claims including the Department of Social and Rehabilitation Services, Juvenile Justice Authority (JJA), Department on Aging (KDOA), Kansas Health Policy Authority, Department of Labor (KDOL), Department of Health and Environment (KDHE) and the State Employee Health Plan (SEHP). The state further provided that the pilot project be implemented in such a manner as to coordinate with the federal requirements to establish a Medicaid Recovery Audit Contract pursuant to the federal Patient Protection and Affordable Care Act, H.R. 3590 (PPACA).

The RAC Program's mission is to reduce Medicaid and CHIP improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the identification of actions that will assist KHPA in preventing future improper payments.

CMS is required to actively review Medicaid payments for services to determine accuracy and if errors are noted to pursue the collection of any payment that it determines was in error.

Throughout this document, the term “Contractor” is used to refer to the entity responding to this RFP.

4.3 Scope of Work.

The purpose of this contract will be to support KHPA in achieving the requirements set forth in both the PPACA, including regulations on the same issued by HHS or CMS, and the State of Kansas Fiscal Year 2011 budget bill. The identification of underpayments and overpayments for the RAC portion of this RFP (section 4.5.2) shall occur for all claims paid under the Medicaid and CHIP programs, for all medical services for which payment is made by any agency of the State of Kansas for waiver services operated under title XIX and XXI of the Social Security Act, and for any payment for services provided under Chapter 39, Article 7 of the Kansas Statutes Annotated which are provided using exclusively State of Kansas general fund and are commonly referred to as MediKan.

The contract shall also support KHPA in achieving the goals established for it by the State of Kansas’s 2010 legislative session, specifically the House Substitute for Senate Bill 572, signed by the Governor on May 27, 2010. These goals are specifically addressed in sections 4.5.3.

This RFP is being issued prior to CMS regulations defining the requirements for a Medicaid RAC contract being published. It is the expectation of KHPA that the regulations when issued will be similar if not the same in most areas discussed in this RFP. However, any CMS regulations issued for the Medicaid RAC contractor that differ from the requirements or are not included in this RFP will be adopted, accepted and implemented by the contractor selected.

4.4 Deliverables

This contract includes the following deliverables which are defined in detail in the subsequent sections of this contract:

- 4.4.1.** Identifying Medicaid, CHIP and MediKan claims that are underpayments for which any payment was made for any medical services under title XIX and XXI of the Social Security Act, underpayments made for waiver services under TXIX and XXI of the Social Security Act, or underpayments made for services provided under Chapter 39, Article 7 of the Kansas Statutes Annotated which are provided using exclusively State of Kansas general fund and are commonly referred to as MediKan.

- 4.4.2.** Identifying and recouping Medicaid, CHIP and MediKan overpayments for any medical services under title XIX and XXI of the Social Security Act, overpayments made for waiver services under TXIX and XXI of the Social Security Act, or overpayments made for services provided under Chapter 39, Article 7 of the Kansas Statutes Annotated which are provided using exclusively State of Kansas general fund and are commonly referred to as MediKan.
- 4.4.3.** The Contractor shall, as a part of the RFP process, quantify the amount of money that it projects it will be able to recover under this contract. The projection shall be by State of Kansas fiscal year (July 1 – June 30). This amount will be used in the selection of a contractor. If the contractor does not recover the amount projected for a particular fiscal year within 10%, then liquidated damages will apply.
- 4.4.4.** Correspond with any provider which will be affected by an identified overpayment or underpayment identified by the contractor.
- 4.4.5.** The Contractor system shall have the ability to interface with the State of Kansas's Medicaid Management Information System (MMIS), or current Medicaid Claims operating system if different, to report overpayment and underpayment findings on a claim specific level.
- 4.4.6.** For any adverse decision the Contractor shall notify the affected provider of its right to appeal the decision and the process for the provider to appeal the decision. The Contractor shall also provide support to KHPA throughout the administrative appeals process and where applicable, a subsequent appeal to the District court.
- 4.4.7.** The Contractor shall coordinate all of its cost recovery efforts with KHPA, KHPA contractors, other state and federal agencies and contractors of the same that are performing audits or payment reviews of medical services provided in the State of Kansas.
- 4.4.8.** The Contractor shall identify vulnerabilities within KHPA's payment systems. For any identified vulnerability, the Contractor shall assist KHPA, or the applicable state agency/contractor, in developing and implementing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future.
- 4.4.9.** The Contractor shall perform provider outreach to notify provider communities of the Contractor's purpose and direction prior to any cost recovery. The format of the outreach shall be included in Contractor's project plan and shall be approved

by KHPA prior to the Contractor's implementation of the outreach.

- 4.4.10.** The Contractor shall use discretion to ensure that the amount of the information requested and timeframe in which the information is requested from a provider or supplier shall not negatively impact the provider's ability to provide services.
- 4.4.11.** The Contractor shall notify KHPA, or the applicable state agency/contractor, upon identifying potential fraud. After notification of KHPA, the Contractor shall notify the State of Kansas's Medicaid Fraud Control Unit (MFCU) of any potential Medicaid fraud.
- 4.4.12.** The Contractor shall notify identified KHPA staff of any private insurance policy identified by the Contractor that is not currently on file with the fiscal agent for the State of Kansas (Fiscal Agent).
- 4.4.13.** The Contractor shall utilize the imaging system used by KHPA and shall be responsible for paying and maintaining any and all licensing fees used by the Contractor for the imaging system. The Contractor shall be responsible for providing any and all equipment required to scan documents and input them into KHPA's imaging system. KHPA will pass on any discounts on the imaging system licensing that currently are or may become available.
- 4.4.14.** The Contractor shall conduct weekly meetings for the first three months, and then the Contractor shall conduct meetings on at least a monthly basis. The Contractor will record meeting minutes with program integrity staff designated by KHPA. Minutes shall be submitted to KHPA (5) five business days following the date of the meeting.
- 4.4.15.** On at least a monthly basis the Contractor shall produce administrative and fiscal reports required by state and/or federal law or regulations as well as reports requested by KHPA. The Contractor shall also maintain the ability to produce a report requested and designed by KHPA staff (Ad Hoc report reporting capabilities).
- 4.4.16.** In addition to the Medicaid Recovery Audit Contractor deliverables described above, the Contractor shall be required to propose and bid other cost recoveries for medical service programs operated by an agency within the State of Kansas as required by House Substitute for Senate bill 572, signed by the Governor on May 27, 2010 (e.g. enhanced federal match claiming, other potential audits, etc) for this RFP. The Contractor shall be compensated by a percentage of recoveries attained.

4.4.17. Contractor shall also be required to provide certain administrative deliverables such as a business continuity plan including risk management and disaster recovery; a turnover plan; and conflict of interest documentation as provided in subsequent paragraphs of this RFP.

4.4.18. The Contractor shall develop detailed written review guidelines made available to the State as the Contractor's Business Practice Manual (BPM).

4.5 Services to Be Provided

The Contractor shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by KHPA, as needed to perform the Section 4.3 (Scope of Work) and Section 4.5 (Services to Be Provided).

KHPA will provide minimum administrative support which may include standard system changes when appropriate, help communicating with Medicaid contractors and other participating agencies, policies interpretations as necessary and other support deemed necessary by KHPA to allow the Contractor to perform their tasks efficiently. KHPA will support changes it determines are necessary but cannot guarantee timeframes or constants. In changing systems to support greater efficiencies for KHPA, the end product could result in an administrative task being placed on the Contractor that was not previously. These administrative tasks will not extend beyond the scope of this contract.

4.5.1 General Requirements

A. Initial Meeting with Contractor and KHPA Staff

1. Project Plan –

The Contractor's key project staff shall meet with the KHPA Contract Manager (Contract Manager) and relevant KHPA staff within two (2) weeks of the DOA to discuss the project plan. The specific focus will be to discuss the time frames for the tasks outlined below. Within two (2) weeks of this meeting, the Contractor will submit a formal project plan, in Microsoft Project, outlining the resources and time frame for completing the work outlined. It will be the responsibility of the Contractor to update this project plan. The initial project plan shall be for the base year of the contract. As new issues rise the project plan shall be updated.

The project plan shall include the following:

Detailed quarterly projection by vulnerability issue including: a) incorrect procedure code and correct procedure code; b) type of review (automated, complex); c) type of vulnerability (medical necessity, incorrect coding, detailed yearly (fiscal year) projection of cost recoveries, including the Medicaid RAC (section 4.5.2), detailed list of issues the Contractor expects to encounter in the implementation of the cost recoveries, any other items that KHPA may request to be included.)

2. Provider Outreach Plan –

A base debtor/provider outreach plan shall be submitted as part of the proposal. KHPA will use the base debtor/provider outreach plan as a starting point for discussions during the initial meeting. Within two weeks of the initial meeting the Contractor shall submit to the Contract Manager a detailed debtor/provider Outreach Plan. The base debtor/provider outreach plan at a minimum shall include potential outreach efforts to associations, providers and Medicaid contractors.

KHPA will announce the use of the RAC. All other debtor/provider education and outreach concerning the use of Contractor will be the responsibility of the Contractor. The Contractor shall only educate providers on their business, their purpose and their process. The Contractor shall not educate providers on Medicaid policy or any other medical or pharmacy policy. The Contract Manager shall approve all presentations and written information shared with the provider, beneficiary, and/or other debtor communities before use.

The Contractor is encouraged to develop and maintain a webpage to communicate to the provider community helpful information (e.g., who to call for an extension, how to customize the address for a medical record request letter). If the Contractor so chooses, the Medicaid information must appear on pages that are separate and distinct from any other non-Medicaid work the Contractor may have. The Contractor shall obtain prior KHPA approval for all Medicaid webpage content.

3. Contractor Organizational Chart –

A draft “Contractor Organization Chart” shall be submitted as part of the proposal. The organizational chart shall identify the number

of key personnel and the organizational structure of the Contractor effort. While KHPA is not dictating the number of key personnel, it is KHPA's opinion that one key person will not be adequate for the state. An example of a possible organizational structure would be a key person overseeing a different claim type (Inpatient, Physician, DME, etc.). This is not prescriptive and KHPA is open to a variety organizational structures. A detailed organizational chart extending past the key personnel shall be submitted within two weeks of the initial meeting. The "Contractor Organizational Chart" shall take into consideration the staffing requirements of section 4.5.5.E.

B. Monthly Meetings/ Conference Calls

Meetings may be held through conference calls. At KHPA's request a meeting(s) shall take place in person at the offices of KHPA. For the first three (3) months after the DOA, the Contractor shall conduct weekly meetings with the Contract Manager and other designated KHPA staff. After the initial three months of the contract, the Contractor shall require its key project staff to participate in a meeting with the Contract Manager and other designated KHPA staff on at least a monthly basis.

The meetings shall be to discuss the progress of the work, evaluate any problems, discuss findings, and discuss plans for immediate next steps of the project and process improvements that will facilitate KHPA in paying claims accurately in the future. The Contractor will be responsible for setting up the meetings, preparing an agenda, documenting the minutes of the meeting and preparing any other supporting materials as needed. The minutes of the meeting shall be provided to KHPA within 5 (five) business days from the date of the meeting.

The Contractor will be required to attend monthly Medicaid Fraud Control Unit (MFCU) meetings at the State of Kansas's Attorney General's Office. The Contractor may call into the meeting.

C. Monthly Reports

The Contractor shall produce and distribute monthly administrative progress reports outlining all work accomplished during the previous month. The reports shall be produced and distributed within established

timeframes and according to the format, content and media specified by the state, at a minimum these reports shall include the following:

1. Complications Completing any task;
2. Communication with Fiscal Agent;
3. Upcoming Debtor/Provider Outreach Efforts;
4. Update of Project Plan;
5. Update of what vulnerability issues are being reviewed in the next month; including how vulnerability issues were identified and what potential vulnerabilities cannot be reviewed because of potentially ineffective policies;
6. Recommended corrective actions for vulnerabilities (i.e. LCD change, system edit, provider education, etc);
7. Update on Joint Operating Agreements (“JOA”);
8. Action Items;
9. Appeal Statistics;
10. Process Improvements to be completed by Contractor.

The Contractor shall produce and distribute monthly financial reports outlining all work accomplished during the previous month. The reports shall be produced and distributed within established timeframes and according to the format, content and media specified by the state. At a minimum the reports shall include the following

1. Overpayments Identified;
2. Overpayments Collected - Amounts shall only be on this report if the amount has been collected by the Fiscal Agent for the State of Kansas;
3. Underpayments Identified;
4. Underpayments Paid Back to Provider - Amounts shall only be on this report if the amount has been paid back to the provider by the Fiscal Agent for the State of Kansas;
5. Overpayments Adjusted - Amounts shall be included on this report if an appeal has been decided in the provider’s favor or if the Contractor rescinded the overpayment after adjustment occurred;
6. Claims report – Number of claims reviewed by claim type, and provider type and specialty;
7. Any report requested and designed by a KHPA staff, an Ad Hoc report.

At KHPA's discretion additional standardized monthly report(s) may be required. If a standardized monthly report is required, KHPA will assist the contractor in defining the report content and format. All monthly reports shall be submitted by the close of business on the fifth business day following the end of the month by email to the Contract Manager or designee with the invoice. The contractor must have the capability to securely transfer reports to KHPA or other authorized parties electronically.

D. Access to Data

The Contractor shall pay for any charges associated with the transfer of data. This includes, but is not limited to, cartridges, data communications equipment, software, lines, messenger service, mail, etc. The Contractor shall pay for all charges associated with the storage and processing of any data necessary to accomplish the demonstration. The Contractor shall establish and maintain back-up and recovery procedures to meet industry standards. The Contractor shall comply with all KHPA privacy and security requirements. The Contractor shall be responsible for all personal computers, software, printers and equipment necessary to accomplish the contract throughout the contract term.

1. Retrieving and Sending Medicaid Data for the State of Kansas

The Contractor shall have the ability to interface with the Fiscal Agent to retrieve data for its queries. The data retrieval shall occur on at least a weekly basis.

Each and every bidding contractor shall describe its data tracking system as a requirement of this RFP. The data tracking system shall at a minimum be able to identify claims or claim records within the Contractor's data repository on which it has identified overpayments or underpayments, on which the Contractor is currently working to identify overpayments or underpayments, and claims on which the Contractor has completed work but did not identify overpayments or underpayments. The Contractor shall compile a list from this tracking system of overpayments and underpayments identified and ready for action by the Fiscal Agent. This list of overpayments and underpayments shall be sent to the Fiscal Agent via interface at least weekly. The Contract Manager and other designated KHPA personnel shall have access to the Contractor's data tracking system.

2. Retrieving SEHP Data for the State of Kansas

The Contractor shall have the ability to retrieve SEHP data from a FTP site that will be set up and maintained by SEHP.

3. Data Manipulation

The Contractor shall maintain the ability to store and manipulate the data that it obtains from KHPA, the Fiscal Agent, or any other source in the State of Kansas. Any bidding contractor must describe its ability to store and manipulate any data received under this RFP.

E. Document Maintenance and Case Files

1. Imaging System

The Contractor shall use the same imaging system as KHPA. Currently that system is Perceptive Software's ImageNow. The Contractor shall determine how many licenses it needs to complete the RFP requirements and shall be responsible for the purchase and maintenance of those licenses.

The case file, referenced in section 4.5.2.2.C shall be maintained on KHPA's imaging system. Any files maintained for section 4.5.3 that involve Medicaid, MediKan or SEHP shall also be maintained on KHPA's imaging system. The Contractor will be responsible for uploading any documents received to the proper case file within one week (five business days) of receipt of the documentation.

If a cost recovery under section 4.5.3 involves programs and medical or pharmacy services provided outside of the scope of Medicaid, SEHP or other programs operated under KHPA, then the sister agency with direct oversight of the program may request that the Contractor have the ability to use a different imaging system than ImageNow.

2. Document Tracking System

Each and every bidding contractor shall describe its document tracking system as a requirement of this RFP.

3. Case File Maintenance

The Contractor shall maintain a case file for every overpayment and underpayment that is identified, including documentation of subsequent recovery and payment efforts. This file shall include documentation of all processes followed by the contractor including a copy of all correspondence, including demand letters, a telephone log for all conversations with the debtor/provider or other any other individuals on behalf of the debtor/provider, and all

collection activities (including certified/registered mail receipts, extended repayment agreements, etc). The case file shall be electronic and maintained on KHPA's imaging system. KHPA shall provide adequate storage for all electronic and imaged documentation that is imaged using the ImageNow software.

For any and all cost recovery implemented through section 4.5.3 of this section the Contractor shall also maintain a case file as approved by the Contract Manager or other KHPA designated personnel for that specific cost recovery.

The Contractor shall maintain a log of all requests for medical records indicating at least the requester, a description of the medical record being requested, the date the request was received, and the date the request was fulfilled. The Contractor shall make information about the status of a case (outstanding, received, review underway, review complete, case closed) available to debtor/providers upon request.

4.5.2 Medicaid Recovery Audit Contractor (RAC)

Throughout this document, the terms "overpayment," "Medicaid overpayment" and "Medicaid underpayment" are used interchangeably to refer collectively to overpayments and underpayments made by any Title XIX, Title XXI or waiver program operating under title XIX or title XXI, or the MediKan program administered by the State of Kansas. The Contractor shall pursue the identification of Medicaid and MediKan claims which contain improper payments.

4.5.2.1 Identification of Medicaid Overpayments

A. Improper payments INCLUDED in this Statement of Work

Unless prohibited in Section 4.5.2.1.B, the Contractor shall attempt to identify improper payments that result from any of the following:

- 1.** Incorrect payment amounts (exception: in cases where KHPA issues instructions directing contractors to not pursue certain incorrect payments made);
- 2.** Non-covered services;
- 3.** Incorrectly coded services (including DRG miscoding);
- 4.** Duplicate services;
- 5.** Lack of eligibility at the time of payment;
- 6.** Situations where Medicaid paid a claim to a provider as the primary payer and another group health plan insurer paid the claim as the primary payer (post pay review process);

7. The Contractor may find the claim to be an overpayment if medical records are requested and not received within 30 calendar days without good reason. Providers may be given additional time if requested and approved. Additional letters/calls are at the discretion of the Contractor.

B. Improper Medicaid payments EXCLUDED from this Statement of Work

The Contractor may not attempt to identify improper payments arising from any of the following:

1. **Claims limitation based on the date of the initial determination**

The Contractor shall not attempt to identify any overpayment more than 4 (four) years past the date of the initial determination made on the claim. The Contractor shall not attempt to identify any underpayment more than 2 (two) years past the date of the initial determination made on the claim. Any overpayment or underpayment inadvertently identified by the Contractor after this timeframe shall be set aside. The Contractor shall take no further action on these claims except to indicate the appropriate status code in its document tracking system. The identification date by the Contractor begins on the mailing date of the medical record request letter or demand letter.

Note: KHPA reserves the right to limit the time period available for Contractor review by claim type, by provider type, by whether or not the provider is active and billing, or by any other reason where KHPA believes it is in the best interest of the Medicaid program to limit claim review. This notice will be in writing, may be by email and will be effective immediately.

2. **Claims where the beneficiary is liable for the overpayment**

The Contractor shall not attempt to contact a beneficiary when the beneficiary is liable for the overpayment. The Contractor may not attempt recoupment from a beneficiary. The Contractor shall compile a list of all overpayments identified that are the responsibility of a beneficiary and at least monthly shall give the list to the Contract Manager and to the applicable program manager for the program.

3. Random selection of claims

The Contractor shall not rely solely on the use of random review in order to identify cases for which it will order medical records from the provider. Instead, the Contractor shall also utilize data analysis techniques in order to identify those claims most likely to contain overpayments. This process is called “targeted review”. The Contractor may not target a claim solely because it is a high dollar claim but may target a claim because it is high dollar and contains other information that leads the Contractor to believe it is likely to contain an overpayment.

The Contractor also may not rely on the use of extrapolation for its findings. The Contractor must have supporting evidence of a Medicaid Overpayment for every claim that it identifies.

4. Prepayment Review

The Contractor shall only identify Medicaid improper payments using the post payment claims review process and not a prepayment review process. Any other source of identification of a Medicaid overpayment or underpayment (such as prepayment review) is not included in the scope of the Medicaid RAC section of this RFP (section 4.5.2).

5. Overlapping Reviews

In order to minimize the impact on the provider community, it is critical that the Contractor avoids situations where the Contractor and another entity are working on the same claim. Therefore, the Contractor will coordinate all of its reviews and audits with other KHPA contractors, sub-contractors, KHPA’s sister agencies and the contractors for the sister agencies in the State of Kansas that review Medicaid claims, MFCU and any other party that KHPA designates. This coordination will be noted in each JOA that the Contractor enters into (see Subsection 4.5.5.C of this section for further information on JOA’s).

If the Contractor finds that a claim has been previously reviewed or is currently under review by another contractor, KHPA or another agency for the same circumstance for which the Contractor was going to conduct its audit, then the Contractor is not permitted to review that claim. Providers and claims can be reviewed multiple times, as long as the scope of the review is different. For example a provider or a claim may be

reviewed for an overpayment and for fraud without an overlap. If there is a question as to whether a claim is excluded by a prior review, then the Contractor may request a decision from KHPA. KHPA's decision on whether the claim or scope of review in question is excluded shall final.

6. Minimum Overpayment Amount

The Contractor shall not attempt to identify any claim for recoupment if the amount of the overpayment is less than \$10.00, unless the Contractor can demonstrate that the overpayment is part of a billing pattern that results in repeated overpayments of less than \$10.00.

4.5.2.2 Obtaining Medical Records for reviews

A. Obtaining Medical Records

Whenever needed for reviews, the Contractor may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the Contractor through a form letter approved by the Contract Manager.

When onsite review results in an improper payment finding, the Contractor shall copy the relevant portions of the medical record and retain them for future use. If the onsite review results in no finding of improper payment, the Contractor need not retain a copy of the medical record.

If the Contractor attempts an onsite visit and the provider refuses to allow access to their facility, the Contractor may not make an overpayment determination based upon the lack of access. Instead, the Contractor shall request the needed records in writing. The Contractor may request Contract Manager's assistance in obtaining the requested medical records if the provider continues its refusal.

B. Limits on Excessive Requests

When requesting medical records the Contractor shall use discretion to ensure the number of medical records in the request will not negatively impact the provider's ability to provide care and that the request is not disproportionate to the potential overpayment. At KHPA discretion, KHPA may institute a medical record request limit. Different limits may apply for different provider types and for hospitals the limit may be based on size of

the hospital (number of beds).

C. Updating the Case File

The Contractor shall include the following in the case file (See Section 4.5.1.E.3 for additional case record maintenance instructions.)

- A copy of all request letters,
- Contacts with KHPA, MFCU, SRS, KDOA, or JJA,
- Dates of any calls made, and
- Notes indicating what transpired during the call.

4.5.2.3 The Overpayment Claim Review Process

A. Types of Determinations the Contractor may make

When the Contractor reviews a claim, they may make any or all of the determinations listed below.

1. Coverage Determinations

The Contractor may find a full or partial overpayment exists if the service is not covered (i.e., it fails to meet one or more of the conditions for coverage listed below). In order to be covered by Kansas Medical Assistance Program (KMAP), a service must:

- a.** Be included in one of the benefit categories described in Title XIX of the Social Security Act (and regulations on the same), State laws and regulations governing Title XIX and/or in KMAP manuals, policies and rules, as well as State Plan Amendments;
- b.** Be included in one of the benefit categories described in Title XXI of the Social Security Act (and regulations on the same), State laws and regulations governing Title XXI and/or in KMAP manuals, policies and rules, as well as State Plan Amendments;
- c.** Be included as a waiver service as allowed under 42 U.S.C. 1396n(b)-(c) and contained in an approved waiver application for utilization in the State of Kansas;

- d. Be included as a service provided under Chapter 39, Article 7 of the Kansas Statutes Annotated which are provided using exclusively State of Kansas general fund and are commonly referred to as MediKan.
- e. Not be excluded from coverage; and
- f. Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 - 1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
 - 2. Furnished in a setting appropriate to the patient's medical needs and condition;
 - 3. Ordered and furnished by qualified personnel;
 - 4. One that meets, but does not exceed, the patient's medical need; and
 - 5. At least as beneficial as an existing and available medically appropriate alternative.

The Contractor must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary service denials. Statutory exclusion denials take precedence over reasonable and necessary denials.

2. Coding Determinations

The Contractor may find that an overpayment or underpayment exists if the services were not correctly coded (i.e., it fails to meet one or more of the coding requirements listed in a National Coverage Determination (NCD), local coding article, Coding Clinic, Current Procedural Terminology (CPT) or CPT Assistant.)

3. Other Determinations

The Contractor may determine that an overpayment or underpayment exists if the claim was paid twice (i.e., a duplicate claim) or was priced incorrectly.

4. Minor Omissions

The Contractor shall not make denials on minor omissions such as missing dates or signatures. If the Contractor makes

any such findings, the findings shall be referred to the Contract Manager as well as to the appropriate state agency program manager responsible for the program for review. This referral shall occur on at least a monthly basis.

B. Medicaid Policies

The Contractor shall comply with all KMAP policies, procedures and manuals, with all state and federal laws, regulations and standards. In addition, the Contractor shall comply with all relevant joint signature memos and State Medicaid Director letters forwarded to the Contractor by the Contract Manager.

The Contractor should not apply a policy or procedure retroactively to claims processed prior to the effective date of the policy or procedure unless the policy or procedure indicates that it should be retroactively applied.

If an issue is brought to the attention of KHPA by any means and KHPA instructs the Contractor on the interpretation of any policy and/or regulation, the Contractor shall abide by KHPA's decision.

C. Evidence

The Contractor shall only identify an overpayment where there is supporting evidence of the overpayment. There are two primary ways of identification:

- 1. Automated Review.** Automated review occurs when the Contractor makes a claim determination at the system level without a human review of the medical record.

a. Coverage/Coding Determinations Made Through Automated Review

The Contractor may use automated review when making coverage and coding determination only where BOTH of the following conditions apply:

- there is certainty that the service is not covered or is incorrectly coded, AND
- a written Medicaid policy or coding guideline exists

When making coverage and coding determinations, if no certainty exists as to whether the service is covered or correctly coded, the Contractor shall not use automated review. When making coverage and coding determinations, if no written Medicaid

policy or coding guideline exists, the contractor shall not use automated review. Examples of coding guidelines include: CPT statements, CPT Assistant statements, and Coding Clinic statements.

EXCEPTION: If the Contractor identifies a “clinically unbelievable” issue (i.e., a situation where certainty of non-coverage or incorrectly coding exists but no Medicaid policy or coding guidelines exist), the Contractor may seek KHPA approval to proceed with automated review. Unless or until KHPA approves the issue for automated review, the Contractor must make its determinations through complex review.

b. Other Determinations Made Through Automated Review

The Contractor may use automated review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often don’t exist for these situations.

- 2. Complex Review.** Complex review occurs when a Contractor makes a claim determination utilizing human review of the medical record. The Contractor may use complex review in situations where the requirements for automated review are not met or the Contractor is unsure whether the requirements for automated review are met. Complex medical review is used in situations where there is a high probability (but not certainty) that the service is not covered or where no Medicaid policy or coding guideline exists. Complex copies of medical records will be needed to provide support for the overpayment.

a. Individual Claim Determinations

The term “individual claim determination” refers to a complex review performed by the Contractor in the absence of a written Medicaid policy or coding statement. When making individual claim determinations, the Contractor shall utilize appropriate medical literature and apply appropriate clinical judgment. The Contractor shall consider the broad range of available evidence and evaluate its quality before making individual claim determinations. The extent and quality of supporting evidence is vital to defending challenges

to individual claim determinations. Individual claim determinations which challenge the standard of practice in a community shall be based on sufficient evidence to convincingly refute evidence presented in support of coverage. The Contractor shall ensure that their Contractor Medical Director (“CMD”) or other adequately trained medical professionals are actively involved in examining all evidence used in making individual claim determinations and acting as a resource to all reviewers making individual claim determinations.

b. Timeframes for Completing a Complex Review

The Contractor shall complete their complex reviews within 100 calendar days of obtaining the requested documentation. The Contractor may request a waiver from KHPA if an extended timeframe is needed due to extenuating circumstances.

3. Summary of Automated vs. Complex. The chart below summarizes these requirements.

Complex Review (with medical record)		Automated (without medical record)					
		Coverage/Coding Determinations				Other Determinations (duplicates, pricing mistakes, etc)	
Written Medicaid policy or coding guidelines exists	No written Medicaid policy or coding guidelines exists	Written Medicaid policy or coding guidelines exists	No written Medicaid policy or coding guidelines exists				
		Certainty exists	NO Certainty exists	Certainty exists	NO Certainty exists	Certainty exists	NO Certainty exists
Allowed	Allowed (often called “Individual Claim Determinations”)	Allowed	Not allowed	Allowed with prior KHPA approval (often called “clinically unbelievable” situations)	Not allowed	Allowed	Not allowed

D. Activities Following Review

1. Rationale for Determination. The Contractor shall document the rationale for the determination. This rationale

shall list the review findings including a description of the Medicaid policy or rule that was violated and a statement as to whether the violation

- a. Resulted in an overpayment; or
- b. Did not affect payment.

The Contractor shall make all rationales available to KHPA upon request.

2. Communication with Providers.

After identification and validation, if necessary, the Contractor shall send written notification of the overpayment to the provider. The Contract Manager shall approve all written notifications to the provider before any letters can be sent. Written notification to the provider shall occur prior to a Medicaid overpayment is sent to the Fiscal Agent for recoupment. Medicaid providers shall be informed not to send in refund checks, but to wait for recoupment which will be specified by KHPA at a later date.

If the same claim is under review by the Contractor for concurrent reviews, then the Contractor shall send the provider only one review results letter per claim. For example, a Contractor may NOT send the provider a letter on January 10 containing the results of a medical necessity review and send a separate letter on January 20 containing the results of the correct coding review for the same claim. Instead, the Contractor must wait until January 20 to inform the provider of the results of both reviews in the same letter.

a. Automated review

The Contractor shall communicate to the provider the results of each automated review that results in an overpayment determination. The Contractor shall inform the provider of which coverage/coding/payment policy or article was violated. The contractor need not communicate to providers the results of automated reviews that do not result in an overpayment determination. The Contractor shall record the date and format of this communication in its document tracking system.

b. Complex review

The Contractor shall communicate to the provider the results of every complex review (i.e., every review where a medical record was obtained), including cases where no improper payment was identified. In cases where an improper payment was identified, the Contractor shall inform the provider of which coverage/coding/payment policy or article was violated. The Contractor shall record the date and format of this communication in its document tracking system.

3. Determine the Overpayment Amount

a. Full denials

A full denial occurs when the Contractor determines that:

- 1) No service was provided; or
- 2) Another payor should have been primary and the provider received full payment from the third party payor.

The overpayment amount is the total paid amount for the service in question.

b. Partial denials

A partial denial occurs when the Contractor determines that:

- 1) The submitted service was up coded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made.
- 2) Another payor should have been primary and the provider received partial payment from the third party payor.

Note: Other situations that are not categorized above should be brought to KHPA's attention before the Contractor sends notification to the provider.

In these cases, the Contractor must determine the level of service that was appropriate based upon Medicaid rules and regulations and the medical record reviewed or represents the correct code for the service described in the medical record. The Contractor will be provided adequate education in how to identify the correct payment for codes and

services by the Fiscal Agent. The overpayment can only be the difference between the paid amount and the amount that should have been paid. The Fiscal Agent shall proceed with any necessary recoupment.

c. Recording the Improper Payment Amount in the Data Tracking System

The Contractor shall update the data tracking system with:

- 1) The improper payment amount for each claim in question
- 2) Line level claim detail with overpayment or underpayment amounts;

Once an overpayment is identified, the Contractor shall send a recoupment file to the Fiscal Agent. The Fiscal Agent shall recoup the identified monies.

d. Re-openings of Claims Denied due to Failure to Submit Requested Medical Documentation

In cases where the Contractor identifies an overpayment without reviewing the medical record because the requested records were not received or were not received timely and the overpayment determination is appealed or the provider submits documentation after the timeline given and requests a review, the Contractor shall begin the review/audit with the documentation submitted by the provider.

The Contractor shall review the claims appealed by the provider within 15 business days of the appeal request. Within 5 business days of reviewing the claims, the Contractor shall suggest to the Contract Manager, based upon the Contractor's findings, whether to defend the appeal, or drop the original overpayment finding. In addition, the Contractor shall issue a new letter containing the revised review results, if requested by the Contract Manager.

E. Potential Quality Problems

The Contractor shall report potential quality issues immediately to the Contract Manager and/or KHPA designated staff.

F. Assisting KHPA in the development of the Medicaid Improper Payment Prevention Plan

Through monthly meetings, monthly reports and any other notification the Contractor shall assist KHPA in the identification of vulnerabilities within the Medicaid system. The contractor shall assist KHPA and any state agency managing the services involved in the development of the Medicaid Improper Payment Prevention Plan. The Medicaid Improper Payment Prevention Plan is a listing of every vulnerability identified by the Contractor that KHPA or appropriate state agency may need to address through policy, provider education or system edits.

G. Referrals to and from KHPA

1. Referrals from KHPA

At KHPA discretion, the Contractor may receive referrals or “tips” on potential overpayments from KHPA. The Contractor shall work with the appropriate entities concerning formats and transfer arrangements. The Contractor must consider all referrals, but is not required to pursue all referrals.

2. Referrals from the Contractor to KHPA

The Contractor may refer Medicaid occurrences to KHPA or one of its sister agencies for investigation. KHPA and its sister agencies will accept the referral, but are not required to pursue all referrals. KHPA and its sister agencies are also not required to follow up with the Contractor on the referrals.

4.5.2.4 Underpayments

The Contractor will review claims, using automated or complex reviews, to identify potential Medicaid underpayments. Upon identification the Contractor will communicate the underpayment finding to the Fiscal Agent. The mode of communication and the frequency shall be agreed upon by both the Contractor and the Fiscal Agent, though it shall be at least weekly. This communication shall be separate from the overpayment communications.

The Contractor will issue a written notice to the provider. This underpayment notification letter shall include the claim(s), identified by ICN, and beneficiary detail. A form letter shall be approved by the

Contract Manager before issuing the first letter.

For purposes of the Medicaid RAC program, a Medicaid underpayment is defined as: those lines or payment group on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The Contractor will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. If changes to the diagnosis, procedure or order in that line or payment group would create an underpayment, the Contractor will identify an underpayment. Service lines or payment groups that a provider failed to include on a claim are not considered underpayments for the purposes of the program.

A. Examples of an Underpayment

1. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy)
2. A diagnosis/condition was left off the Medicaid claim but appears in the medical record. Had this diagnosis or condition been listed on the Medicaid claim, a higher payment group would have been the result.

The following will **NOT** be considered an underpayment:

1. The medical record indicates that the provider performed additional services such as an EKG, but the provider did not bill for the service. (This provider type is paid based on a fee schedule that has a separate code and payment amount for EKG)
2. The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided however the additional minutes do not affect the group or the price. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)

B. Provider Inquiries

The Contractor shall have no responsibility to accept case files from providers for an underpayment case review. If case files are received from providers that were not requested by the Contractor, the Contractor may shred the record requests. The Contractor is under no obligation to respond to the provider.

C. Medical Record Requests

The Contractor may request medical records for the sole purpose of identifying an underpayment. If records are requested for an underpayment determination, then the record requests and record retention shall be treated in the same manner as if the records were for an overpayment determination.

D. Appeal of the Underpayment Determination

The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the Contractor rebuttal process and discuss the underpayment determination with the Contractor. If the provider disagrees with the Contractor that an underpayment exists, the Contractor shall defer to the billing provider's judgment and request that the Fiscal Agent "undo" the underpayment. In addition, the Contractor shall forward all supporting documentation, including the validation from the Fiscal Agent to the Contract Manager.

E. Underpayment Minimum Amount

The Contractor shall not attempt to identify any underpayment that is less than \$50.00.

4.5.2.5 Recoupment of Overpayments

The Contractor will pursue the recoupment of Medicaid overpayments that are identified through Section 4.5.2.1. The recovery techniques utilized by the Contractor shall be legally supportable. The recovery techniques shall follow the guidelines of all applicable KHPA policies, regulations and manuals as well as all federal laws and regulations.

A. Recoupment

KHPA utilizes recoupment, as defined in 42 CFR 433.304 to recover a large percentage of all Medicaid provider overpayments. Overpayments identified and sent to the Fiscal Agent for recoupment by the Contractor will also be subject to the existing recoupment procedures.

Recoupment of present and/or future payments will be performed by the Fiscal Agent. These recoupment procedures will be used for all provider overpayments.

The Provider shall have 60 days after the written notification of overpayment letter is sent, prior to any recoupment taking place. This shall allow time for an administrative review, if one is requested, prior to any recoupment.

The recoupment remains in place until the debt is satisfied in full or alternative payment arrangements are made. As payments are recouped they are applied against the oldest outstanding overpayment. The debt receiving the payments may or may not have been determined by the Contractor.

The Contractor will receive a contingency payment, as stated in Section 4.5.4, for all amounts recovered through recoupments that are applied to the principal amount verified and demanded by the Contractor.

B. Adjustments to Claims Determinations

The Contractor shall not forward claims to the Fiscal Agent for adjustment if the claim is incorrectly coded but the coding error does not equate to a difference in the payment amount. For example, HCPCS code xxxxx requires a modifier for payment. Payment with the modifier is \$25.50 per service. Without the modifier payment is \$25.50 per service. While the claim without the modifier is incorrect, there is no overpayment or underpayment and the claim shall not be forwarded for adjustment.

Sometimes when the system adjusts the claim for the Contractor identified overpayment other lines are adjusted because of system edits. These additional lines are associated findings. While the Contractor did not identify these lines for adjustment, they were initiated because of the Contractor adjustment. The Contractor receives credit for the entire claim adjustment and the Contractor shall include these additional lines and denial reason codes on the written notification to the provider.

When partial adjustments to claims are necessary, the Fiscal Agent shall downcode the claim whenever possible. The Contractor will only be paid a contingency payment on the difference between the original claim paid amount and the revised claim paid amount. Some examples include DRG validations where a lower-weighted DRG is assigned, claim adjustments resulting in a lower payment amount, inpatient stays that should have been billed as outpatient, etc. If the system cannot currently accommodate this type of downcoding/adjustments, KHPA will work with the system engineers to create the necessary changes if deemed possible.

C. Referral to the Department of Administration, State of Kansas Debt Recovery System

Once a recoupment is set up by the Fiscal Agent, the Administrative Recoupment (A/R) shall follow the same timeline and guidelines that the Fiscal Agent follows for all other A/Rs. This means that if the A/R is still open after as little as 70 days after the initial recoupment is set to occur, without certain action from the provider, the debt will be referred to the State of Kansas Debt Recovery System in the Department of Administration (DSO). Once a cost recovery is referred to DSO, then the Contractor shall receive 50% of its normal contingency fee on any money recovered on that debt.

D. Compromise and/or Settlement of Overpayment

The Contractor shall not have any authority to compromise and/or settle an identified or possible overpayment. If a debtor presents the Contractor with a compromise request, the Contractor shall forward the overpayment recovery claim case and all applicable supporting documentation to the Contract Manager or other KHPA designated staff as well as the appropriate state agency program manager for direction. The Contractor must include its recommendation on the request and justification for such recommendation.

If the Contract Manager and the appropriate state agency program manager determine that a compromise and/or settlement is in the best interests of Medicaid and the State of Kansas, the Contractor shall receive a contingency payment for the portion of principal that was recouped and/or received.

E. Recoupment During MFCU Review

If a case is referred to MFCU and MFCU decides to take the case, then the Contractor must notify MFCU, through the Contract Manager or designee, prior to any administrative action on the case, including recoupment. Any current recoupments on a case referred to and taken by MFCU shall be placed on hold until notice is received from KHPA to proceed with the recoupment.

F. Recoupment During the Appeals Process

The Contractor shall ensure that all demand letters initiated as a result of an identified overpayment in Sections 4.5.2.3.D.2 and

4.5.5.A contain information concerning the provider's fair hearing and other appeal rights, where applicable.

If a provider files an appeal with the appropriate entity within the appropriate timeframes, the Contractor shall follow all KHPA guidance regarding the limitation on recoupment.

Once the Contractor is notified of an administrative appeal request, the Contractor shall notify the Contract Manager or other KHPA designated staff immediately.

All recoupments shall be set for 60 days after the notice of overpayment letter is sent to the provider. The 60 days should allow enough time for resolution of an administrative hearing. Recoupment efforts should continue as normal, unless the Contractor is notified otherwise by the Contract Manager.

If a provider requests a formal appeal through OAH, then all recoupment efforts by the Contractor shall be placed on hold, unless notified differently by the Contract Manager. If the appeal is decided in favor of KHPA, then the recoupments shall proceed as if the provider had not filed an appeal.

4.5.2.6 Supporting Identification of Overpayments in the Medicaid Appeal Process

Providers are given appeal rights if Medicaid overpayments are determined during the post payment review process. If a provider chooses to appeal an overpayment determined by the Contractor, the Contractor shall assist KHPA with support of the overpayment determination throughout all levels of the appeal.

This includes providing supporting documentation with appropriate reference to Medicaid statutes, regulations, manuals and instructions when requested, providing assistance, and representing KHPA at any hearings associated with the overpayment when requested by KHPA.

Providers shall request an appeal through the appropriate Medicaid appeals process. Providers may request an administrative rehearing prior to requesting a formal appeal through OAH. OAH shall adjudicate all formal appeal requests related to provider overpayments identified by the Contractor. Some recovery claims may eventually be appealed to the appropriate district court. If the Contractor receives a written appeal request it shall forward it to the OAH within one business day of receipt and notify KHPA of the same. If the Contractor receives a verbal request for appeal from a provider, the Contractor shall give the provider the

telephone number of the OAH and inform them that their verbal request does not suspend the permissible time frame for requesting an appeal as set forth in the demand letter.

4.5.3 Other Medical Services Cost Recoveries

The scope of the services described in section 4.5.2 may also include health care cost containment and recovery services to be implemented regarding programs of state agencies or programs responsible for the payment of medical or pharmacy claims, including the department of social and rehabilitation services, department on aging, KHPA, juvenile justice authority, department of labor, department of health and environment and the state health care benefits program, as provided in K.S.A 75-6501 through 75-6523, and amendments thereto.

The projects shall be designed to provide statewide efficiencies and cost savings across multiple state agencies and the state health care benefits program. The identified projects shall include any services recover funds for health care services paid by any state agency.

The projects shall be supplemental to audit and recovery projects already conducted by individual state agencies and shall determine ways to improve efficiencies by coordinating audits and recovery program activities across multiple state agencies.

A. Projects Involving Agencies Outside of KHPA

If a proposed cost recovery involves programs and medical or pharmacy services provided outside of the scope of Medicaid, SEHP or other programs operated under KHPA, then the sister agency with direct oversight of the program shall be involved in the development, approval, implementation and oversight of the cost recovery.

4.5.4 Payment and Estimates of Potential Cost Recoveries

A. Payment to the Contractor

The Contractor shall be paid monthly based upon the following:

1. Overpayments Recovered

The Contractor shall be paid on a contingency fee basis only and payment shall be based on the principal amount of money identified by the Contractor and actually recovered.

In order for the Contractor's invoice to be paid, all supporting information for the invoice shall be in the Contractor's data

tracking system and on the listing received from the Fiscal Agent for Medicaid recoveries. If a Medicaid recovery is not listed in both places, the claim will be removed from the invoice and not paid.

Discrepancies must be noted along with supporting documentation

Contingency fees:

- a. The Contractor shall not receive any payments solely for the identification of the overpayments;
- b. The contingency fee will be determined by the overpayments collected without consideration given to the underpayments identified (i.e. without netting out the underpayments against the overpayments.);
- c. The Contractor shall be paid a set percentage of the amount that is collected through its recovery efforts;
- d. The Contractor's contingency fee shall be 50% of the normal set percentage for any of the following recovery efforts:
 - 1) Recovery efforts accomplished through the Kansas Department of Administration, State of Kansas Debt Recovery System offset or another collection vehicle after the debt is referred to the Department of Administration;
 - 2) Recoveries made through the self-disclosure of a provider/debtor if Contractor had initiated a review of the provider prior to the self-disclosure; and
- e. If a provider files an appeal disputing the overpayment determination and the appeal is adjudicated in the provider's/debtor's favor at **ANY** level, the Contractor shall repay KHPA or its sister agency the contingency payment for that recovery. Repayment to KHPA will occur on the next applicable invoice.

2. Underpayments Paid

The Contractor shall be paid a flat negotiated rate for all Medicaid underpayments that have been identified by the Contractor and paid to the provider.

B. Projected Cost Recovery

1. Projected Cost Recovery

The Contractor shall submit, as part of the RFP bidding process, its

projected cost recovery for the Medicaid RAC section of this RFP (4.5.2) as well as any other medical and pharmacy services cost recovery projects that are proposed by the Contractor at the time of the bidding process. The projected cost recovery shall be the Contractor's best estimate of the amount of money that the Contractor will be able to identify and recover for KHPA in each State of Kansas fiscal year (July 1 through June 30), for three fiscal years. The Contractor's projected cost recovery shall be broken down by agency and by the program involved.

2. State Compliance with Data

KHPA will provide each bidder with at least three state fiscal year's worth of general Medicaid claims information and comparable SEHP information that will enable the bidders to make an accurate projection of cost recovery for the RAC as outlined under section 4.5.2. The claims information will not contain PHI and shall include at least the total claims processed by State fiscal year, total claims processed by claim type for State fiscal year and the total dollar amount spent on claims processed by State fiscal year.

3. Liquidated Damages

If, at the end of the State of Kansas's fiscal year (June 30), the Contractor's recoveries are not within 10% of the projected amount of cost recovery for that particular project (RAC or other cost recovery) required under section 4.5.4.B.1, then the Contract Manager shall apply liquidated damages to the Contractor in an amount equal to the difference between the projected recoveries minus 10% and the actual recoveries (e.g. projected recovery of \$100,000 and an actual recovery of \$50,000 would result in damages of \$40,000 $((100,000 * .1) - \$50,000)$). The damages shall be due and owing within five (5) business days from the date that the liquidated damages are applied by the Contract Manager. The state reserves the right to set off liquidated damages against future payments owed to the contractor.

4.5.5 Administrative and Miscellaneous Issues

A. Debtor Notification

Once the Contractor has identified an overpayment, the Contractor shall send the debtor/provider written notification (specific to the RAC in section 4.5.2.3.D.2). At KHPA's discretion, KHPA may utilize a third party contractor to process the administrative functions for the

overpayments and underpayments determined by the Contractor. This may include the financial reporting of the receivable, any claims adjustments necessary to ensure an accurate claims history, the appeal process, depositing the refund check and initiating offset. The Contractor shall have no rights in the selection of a third party contractor to process the administrative functions if KHPA elects to utilize such a third party contractor. The Contractor shall interact cooperatively with the third party contractor on an as-needed basis.

The letters issued by the Contractor shall instruct debtors, other than Medicaid providers to send in refund checks. Medicaid providers shall be informed not to send in refund checks, but to wait for recoupment which will be specified by KHPA at a later date.

B. Point of Contact for Contractor

The primary point of contact for the Contractor shall be Contract Manager (specifically Joshua Mast) or other party that the Contract Manager delegates. Any contact between other state agencies and the Contractor or other contractors and the Contractor, shall flow through the Contract Manager or other party designated by the Contract Manager.

C. Communication with State of Kansas Medical Contractors

1. State of Kansas Medical Contractors

A State of Kansas Medical Contractor is either a contractor that is contracted with one of KHPA's sister agencies, or is one of KHPA's sister agencies that operates any programs and medical or pharmacy services provided outside of the scope of Medicaid, SEHP or other programs operated directly under KHPA (such as a medical program operated by the Department of Labor).

2. Joint Operating Agreements (JOA)

The Contractor shall be required to complete a Joint Operating Agreement with all applicable State of Kansas medical contractors. KHPA shall be included in all JOA's entered into by the Contractor. The JOA shall encompass all communication between the other State of Kansas Medical Contractors and the Contractor. The JOA shall be a mutually agreed to document that is reviewed semi-annually and updated as needed. The JOA shall prescribe 1) agreed upon service levels and 2) notification and escalation mechanisms with KHPA involvement.

D. Fraud

The Contractor shall report all instances of potential fraud immediately to KHPA. If the case involves potential Medicaid fraud, then the case shall also be referred to MFCU. If MFCU decides to pursue any cases, then the Contractor shall suspend any work on the claim until it receives further notice from MFCU or KHPA.

E. Staffing

Any employee of the Contractor may be called as a witness by MFCU in a fraud case. Any employee of the Contractor that MFCU calls as a witness shall be required to attend the deposition or trial as part that employee's employment with the Contractor.

The Contractor may suggest its own organizational structure, but the organizational structure must be approved by KHPA as outlined in section 4.5.1.A.3. The Contractor may also suggest its own minimum staffing requirements, but they must be approved by the Contract Manager.

1. Contractor Medical Director

The Contractor must employ a minimum of one FTE CMD and arrange for an alternate, to be approved by the Contract Manager, when the CMD is unavailable for extended periods. The CMD FTE must be either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience. More than one individual's time cannot be combined to meet the one FTE minimum. The Contractor, however, shall also use additional medical professionals to complement the use of the CMD, see sub-section 2 to this section for more details (i.e. dental consultants, RX consultants, RNs, etc).

a. Relevant Work Experience

1. Prior work experience in the health insurance industry, utilization review firm or health care claims processing organization,
2. Extensive knowledge of the Medicaid program particularly the coverage and payment rules, and
3. Public relations experience such as working with physician groups, beneficiary organizations or Congressional offices.

b. Relevant Educational Experience

Experience practicing medicine as a board certified doctor of medicine or doctor who is currently licensed.

All clinicians employed or retained as consultants must be currently licensed to practice medicine in the United States, and the Contractor must annually verify that the license is current. When recruiting CMDs, the Contractor must give preference to physicians who have patient care experience and are actively involved in the practice of medicine. The CMD's duties relevant to the Contractor are listed below.

- 1) Primary duties include:
 - a) Providing the clinical expertise and judgment to understand Medicaid policy;
 - b) Serving as a readily available source of medical information to provide guidance in questionable claims reviews situations;
 - c) Recommending when provider education, system edits or other corrective actions are needed or must be revised to address Contractor identified vulnerabilities;
 - d) Briefing and directing personnel on the correct application of policy during claim adjudication, including through written internal claim review guidelines;
 - e) Keeping abreast of medical practice and technology changes that may result in improper billing or program abuse;
- 2) Other duties include:
 - a) Interacting with the CMDs at other Contractors and/or RACs to share information on potential problem areas;

To prevent conflict of interest issues, the CMD must provide written notification to KHPA within 3 months after the appointment, election, or membership effective date if the CMD becomes a committee member or is appointed or elected as an officer in any State or national medical societies or other professional organizations. In addition, CMDs who are currently in practice should notify KHPA of the type and extent of the practice.

2. Other Professional Medical Staff

Whenever performing complex coverage or coding reviews (i.e., reviews involving the medical record), the Contractor shall ensure that coverage/medical necessity determinations are made by RNs

or therapists and that coding determinations are made by certified coders. The Contractor shall ensure that it has adequate staffing to perform all duties mandated by this RFP.

The Contractor shall ensure that no nurse, therapist or coder reviews claims from a provider who was their employer within the previous 12 months.

F. Recalled Cases

KHPA may determine that a cost recovery case or a particular uncollectible debt should be handled by KHPA staff and may recall the case/debt for that reason. Should KHPA recall a case/debt for that reason, the Contractor shall immediately stop all activities on the case/debt identified by KHPA for recall and return the case/debt and all related information to KHPA within one (1) business day of the recall request.

The Contractor shall receive no payment, except for monies already recouped, for recalled cases.

G. Internal Guidelines (Business Practice Manual)

As part of its process of reviewing claims for coverage and coding purposes, the Contractor shall develop detailed written review guidelines. The Contractor need not hold public meetings or seek public comments on their proposed internal guidelines. However, they must make their Internal Guidelines available to KHPA for review and approval. The Contractor's internal guidelines shall not create, change or override KHPA policy.

The Contractor shall also include administrative operations and other projects in the BPM. The BPM shall be presented to and approved by the Contract Manager before any reviews occur.

H. Recovery

If the Contractor receives a refund check, the Contractor shall forward the check to KHPA. Before forwarding the check, the Contractor shall image the check and otherwise document these payments. A copy shall be included in the appropriate overpayment case file. The Contractor shall develop and implement a process for forwarding the checks received to KHPA or the appropriate state agency, and that process shall be approved by the Contract Manager or KHPA designee prior to implementation.

I. Audit Support

Should KHPA, the Federal and State OIG, CMS or a CMS authorized contractor choose to conduct an audit of the Contractor, the Contractor shall provide workspace and produce all needed reports and case files within 1 (one) business day of the request. If KHPA, or one of its sister agencies, is audited the Contractor shall provide staff that can perform research needed for the audit and meet with the auditors.

J. Customer Service

The Contractor shall provide a toll free customer service telephone number in all correspondence sent to Medicaid providers or other prospective debtors. The customer service number shall be staffed by qualified personnel during normal business hours from 8:00 a.m. to 5:00 p.m. in the central time zone. After normal business hours, a message shall indicate the normal business hours for customer service. All messages playing after normal business hours or while on hold shall be approved by the KHPA before use.

The staff answering the customer service lines shall be knowledgeable of the RAC program and any other programs that may be implemented by the Contractor under this contract or any amendments thereto. The staff shall have access to all identified overpayments and shall be knowledgeable of all possible recovery methods and the appeal rights of the provider (for provider debts Calls from providers shall be returned within 1 business day. The Contractor shall provide a translation service for non-English speaking providers or other prospective debtors. Access to the translation services shall be immediate.

The Contractor shall respond to written correspondence within 10 days of receipt. The Contractor shall image and file all correspondence received indicating displeasure with the Contractor within ten (10) days of receipt. The Contractor shall notify the Contract Manager or designed of receipt and imaging of the correspondence and its location. If the Contractor is required to respond, the Contractor shall save copies of its response in the same file as the correspondence received. (If the Contractor is not sure how the correspondence will be interpreted, it should forward the correspondence to the KHPA.)

The Contractor shall image a report of contact for all telephone inquiries and supply it to KHPA within 48 hours of any request.

K. Contractor's Quality Assurance

The Contractor shall utilize a Quality Assurance (QA) program to ensure that all customer service representatives are knowledgeable, being respectful to providers and providing timely follow-up calls when

necessary. The QA program shall be described in detail in the proposal.

The Contractor's QA program shall ensure that the Contractor follows all proper laws, regulations, rules and guidance in performing its audits, reviews and special projects. The QA program shall ensure reviews and projects are completed within the required timeframes and that all provider complaints are properly followed up and directed to the correct personnel.

The Contractor's QA program shall be outlined in the Contractor's BPM.

L. KHPA's Quality Assurance

1. The Contractor shall be required to complete a Statement of Auditing Standards No. 70 (SAS 70) Audit. The Contractor shall be responsible for contracting with an independent and certified public accounting (CPA) firm to perform the audit. The CPA firm will ideally have experience in Medicaid operations and must have experience performing SAS 70 Type II audits.

The scope of the audits will be dictated by KHPA and will be determined no later than 180 days after award. A final report from the CPA firm must be submitted to KHPA by the end of each award year. Any corrective action plan must be submitted to KHPA within 45 days of the issuance of the final report.

2. At KHPA's discretion, KHPA may perform a contractor performance evaluation. Advance notice may or may not be given. During the evaluation KHPA reviewers will work from a prescribed audit protocol, review actual cases and issue a final report. Any finding from the review will require a corrective action plan.
3. At KHPA discretion, KHPA may contract with an independent contractor to perform an accuracy audit on the Contractor's identifications.

M. Third Party Liability Information

Any Third Party Liability (TPL) information that the Contractor finds during any of its audits/reviews, shall be sent to the Fiscal Agent. The timing of the TPL file being sent to the Fiscal Agent at a minimum shall be once a month.

N. Business Continuity Plan; Risk Management Plan with Disaster Recovery Plan

Contractor shall provide to KHPA, within 90 days following contract award, with the following plans. Plans will be updated annually and a copy of the updated plans will be sent to the KHPA Contract Manager.

1. Business Continuity Plan.

The Medicaid, CHIP, SEHP and other PHI data and other Contract documents and records must be protected against hardware and software failures, human error, natural disasters, and other emergencies which could interrupt services.

a. Requirements.

- 1)** The plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure.
- 2)** Identify core business processes;
 - a)** Identification of potential system failures for the process.
 - b)** Risk analysis.
 - c)** Impact analysis.
 - d)** Definition of minimum acceptable levels of outputs.
 - e)** Documentation of contingency plans.
 - f)** Definition of triggers for activating contingency plans.
 - g)** Discussion of establishment of a business resumption team.

b. Maintenance of updated disaster recovery plans and procedures.

c. Plan for replacement of personnel

- 1)** Replacement in the event of loss of personnel before or after signing this contract.
- 2)** Replacement in the event of inability by personnel to meet performance standards.
- 3)** Allocation of additional resources in the event of the Contractor's inability to meet performance standards.
- 4)** Replacement/addition of personnel with specific qualifications.
- 5)** Time frames necessary for replacement.
- 6)** The Contractor's capability of providing replacements/additions with comparable experience.

- 7) The Contractor shall ensure that quality of service is not compromised by excessive staff turnover.
- 8) The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the contract, including the State's role in getting the replacement personnel;
- 9) Replacement of staff with key qualifications and experience with new staff with similar qualifications and experience.

2. Risk Management Plan.

The Risk Management Plan is the vendor's identified risks and their proposed solution or action to be taken to alleviate or minimize the consequences in the event that those risks become actuality. The Business Continuity Plan encompasses the Risk Management Plan, the Disaster Recovery Plan, as well as providing additional analysis of the impact of potential risks, disasters, and etc., and further, it also addresses personnel replacement plans, both short term and long term.

O. Fair Hearings

A fair hearing is a formal administrative process. For Medicaid, federal law requires state Medicaid agencies to provide a fair hearing for any applicant, recipient, or interested person who wants to appeal a denial, termination, suspension, or reduction of Medicaid eligibility or covered services. See 42 C.F.R. Part 431, Subpart E. For CHIP, Kansas law requires KHPA to provide a fair hearing to any applicant or other interested person who appeals from the decision or final action of any agent or employee of the KHPA. See K.S.A. 75-3306.

Fair hearings are governed by the Kansas Administrative Procedures Act, K.S.A. 77-513 et seq., and regulations in K.A.R. 30-7-64, et seq., and K.A.R. 129-7-65. The Office of Administrative Hearings (OAH), under the Kansas Department of Administration, conducts the fair hearings. All notices and forms of adverse action shall include an explanation of fair hearing rights in accordance with state and federal rules. If a request for a fair hearing is received by the Contractor, it must be forwarded to OAH immediately.

An appellant who is not satisfied with a decision relating to a denial of Medicaid or CHIP benefits may request a fair hearing. Appellants may be represented by a person of their choosing, such as a lawyer, relative, or friend. A hearing officer will send a notice that a hearing has been requested to the appellant and the agency. An agency summary will be

prepared and the hearing officer will schedule a date for the hearing. After the hearing, which usually includes the submission of exhibits and testimony from witnesses, the hearing officer issues an initial order. If either the appellant or the agency is dissatisfied with the initial order, the dissatisfied party may request the KHPA State Appeals Committee (SAC) to review the decision. The SAC is composed of three (3) individuals selected by the KHPA, and they review the record of the hearing, and issue a “final order.” If the appellant is dissatisfied with the final order, the appellant may seek judicial review in district court.

1. Contractor responsibilities: When an appellant files a request for fair hearing the contractor shall:
 - a. Notify the appropriate KHPA Contractor staff
 - b. Review the appellant’s file
 - c. Re-evaluate the Contractor’s finding/decision when appropriate
 - d. Prepare and distribute summary packets or dismissal as directed by KHPA staff
 - e. Testify at the hearing as directed by KHPA staff
 - f. Maintain a tracking log approved by KHPA.
 - g. Maintain all historical documentation for hearings based on guidelines provided by KHPA.
 - h. Complete additional review and correspondence on hearings referred to SAC.

P. *Grievances*

A grievance is an expression of dissatisfaction about any matter. A grievance shall be filed on behalf of a caller who expresses dissatisfaction, regardless of a specific request to file a grievance. Grievances may include: denial of coverage, partial denial of coverage, not given clear and accurate information from staff, lack of action being taken on an appeal, aspects of the business relationships such as rudeness of an employee or failure to respect the consumer’s rights. A grievance may be received by telephone, voice mail, e-mail, written communication or by a person walking into the Contractor’s place of business.

The grievance process must be in full compliance with all applicable State and Federal laws and regulations and shall not supplant, delay, or hinder the fair hearing process outlined in Section 4.5.5.O.

Contractor Responsibilities:

1. The Contractor is responsible to document, investigate and resolve all grievances received for/from debtors/providers in a courteous and prompt manner.

2. The Contractor will develop policies and procedures approved by KHPA to identify, record, investigate, resolve and report grievances related to Contract services.
3. Referrals to other agency.
 - a. There may be times when the grievance isn't related to the business performed by the Contractor and will need to be referred to the appropriate entity.
 - b. The referral to the other agency would be the resolution by the Contractor.

Q. Turnover Plan

1. Contractor Responsibilities.
 - a. The Contractor must assist KHPA in an orderly transition at the end of this contract should the Contractor be replaced by another entity.
 - b. The Contractor must take no action(s) that will hinder the orderly transition of duties and responsibilities as listed herein, from the contractor to another, separate contractor upon termination of this contract.
 - c. Six (6) months prior to the expiration date of the contract, the Contractor will provide, at no extra charge, assistance in turning over the operations performed under this Contract to the State, or designated agent assigned by the State.
2. Turnover Plan Requirements.
 - a. Must be provided within thirty (30) days of contract award, outlining the following information but not limited to:
 - 1) Proposed approach to transition operations to another vendor;
 - 2) Identification and release of State owned documents;
 - 3) Timely turnover of all records and other necessary data to another review entity or appropriate custodian;
 - 4) Electronic records or files to be turned over to another entity will be in an acceptable format to KHPA, the cost of converting to the format will be the responsibility of the contractor;
 - 5) Maintenance and transition of telephone services, including current 800 numbers;
 - 6) Designation of a knowledgeable person who will be available on a daily basis to assist KHPA during the transition process and for one month following the

- transition date;
 - 7) Proposed timeline delineating the transfer process; and
 - 8) Turnover plan will be resubmitted annually on the anniversary date of contract implementation for review, update and approval by KHPA.
- 3. Turnover Protocol.
 - a. The Contractor will release all documents and records (hardcopy and/or electronic copy) necessary to complete the transfer of operations, and will provide a final report documenting all such actions.
 - b. At the State's option, the Contractor will arrange for the removal of hardware and software, or the transfer of documents, equipment or software leases, where applicable.
 - 1) The Contractor will organize and box all records (hardcopy and/or electronic copy) for shipment to the new Contractor, unless otherwise instructed by KHPA.
 - a) Boxed materials must be labeled on the outside with a list of contents.
 - b) Include an inventory list on each box and clearly indicate the type and date of materials.
 - 2) All review records should be identified and boxed
 - 3) The Contractor will receive specific instructions from KHPA regarding boxing, labeling, and shipment of all records utilized under this contract.
 - c. In the event the Contractor is non-compliant or non-cooperative with the approved transfer plan, KHPA will hold the Contractor responsible for all expenses associated with the delay of the transition and include a ten (10%) percent liquidated damages assessment against the Contractor's final invoice.

R. Conflict of Interest – Required Documentation

- 1. **The Kansas Health Policy Authority (KHPA) intends: To avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, the KHPA reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to KHPA review and prior approval.**

2. Conflicts of interest include, but are not limited to:

- a.** An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the Contract.
- b.** An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

If the KHPA is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) business days from the date of notification of the conflict by the KHPA to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by the KHPA and cannot be resolved to the satisfaction of the KHPA, the conflict will be grounds for terminating the Contract. The KHPA may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

3. Contractor Responsibilities: The Contractor shall submit for KHPA review and approval, a "Conflict of Interest Disclosure Statement" (Disclosure Statement), a "Conflict of Interest Disclosure Statement Questionnaire" (Questionnaire) and as necessary, a "Conflict of Interest Disclosure Avoidance Plan" (Avoidance Plan), using the following timetable:

- a.** Originals two (2) weeks after DOA;
- b.** An update January 1st of each calendar year thereafter;
- c.** The originals completed by new Program personnel within ten (10) business days of their hire; and
- d.** An update completed by Program personnel who experience a change in holdings that may create a real or apparent conflict of interest within ten (10) business days of such change.

The Disclosure Statement shall fully describe any direct or indirect interest the Contractor, any parent or any subcontractor, has in any MCO, PIHP, PAHP, PCCM or other health care provider in the State of Kansas (as defined in Title 42, CFR, Subpart 438.810), together with the name and position description of the Contractor, any parent, or subcontractor employee, director, consultant, or officer about whom the disclosure is being made.

- 4. At a minimum, the Contractor's Disclosure Statement** shall disclose the name and address of any provider, including MCO, PIHP, PAHP, PCCM or other health care providers in the State of Kansas in which:

 - a.** The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employee, director, consultant, or officer has a direct or indirect interest of any dollar amount.
 - b.** The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's or any parent corporation's or any subcontractor's employees, directors, consultants, or officers assigned to the Contract is a director, officer, partner, trustee, employee, or holder of a management position, or is self-employed; and
 - c.** The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employees, directors, consultants, or officers assigned to the Contract, has derived any direct or indirect income within the twelve (12) months immediately prior to the submittal of a proposal.
- 5.** Questionnaires shall be completed by all Contractor Program personnel, and, of those with real or apparent conflict of interests, Avoidance Plans shall be completed. The Contractor shall provide copies of all Questionnaires, and as necessary, all Avoidance Plans, to the KHPA using the timetable described above.
- 6.** The Contractor shall disclose the name of any proposed subcontractor, consultant, officer, director, or employee who was employed by the State of Kansas, the KHPA, the Governor's Office, Health and Human Services Agency, State Controller's Office, Office of the Attorney General, and/or the Legislature as of July 1, 2008.
- 7.** If a real or apparent conflict exists, the Contractor shall, together with

the Disclosure Statement and Questionnaire, submit an Avoidance Plan and procedures to hold separate such relationships and/or to safeguard against conflicts. If the Contractor has nothing to disclose under this section, it shall so certify in its Disclosure Statement.

8. The Contractor shall furnish to the Kansas Health Policy Authority the ownership and control information required by Title 42, CFR, Subpart 438.810 prior to CED.
9. The Contractor's Representative, or the selected designee, shall certify under penalty of perjury that such reports and updates to such reports are accurate, complete and current to the best of that individual's knowledge and belief unless the requirement is expressly waived by the Contracting Officer in writing.
10. The Avoidance Plan shall include procedures to:
 - a. Guard against conflict of interest;
 - b. Hold separate any disclosed relationships or any potential conflict of interest relationships that could arise during the life of the Contract, including but not limited to such problematic matters as financial interactions, reporting, sharing of office space, staff interactions, or Contractor fulfillment of Contract responsibilities; andEnsure that the Contractor shall discharge its responsibilities and duties with disinterested skill, zeal, diligence, and that no Contractor's, parent corporations, or subcontractor's employee, officer, director, or consultant will be in a position to exploit that position for private benefit or for other Contractor, or parent corporation or subcontractor interests which are or may be in conflict with Kansas Health Policy Authority interests.

S. LIQUIDATED DAMAGES

1. Purpose

The purpose of liquidated damages is to ensure adherence to the performance requirements in the contract. Damages are not intended to be punitive. It is agreed by the State and the Contractor that, in the event of a failure to meet the performance requirements listed below damage shall be sustained by the State, and that it is and shall be impractical and extremely difficult to ascertain the actual damages which the State shall sustain in the event of, and by reason of, such failure. It is therefore agreed that the Contractor shall pay the State for such failures at the sole discretion of the State according to the following sections found in

the table below in section 4.5.5.T.

Damage assessments are linked to performance of system implementation or operational responsibilities. Where an assessment is defined as an "up to \$, \$\$\$" amount, the dollar value shall be set at the discretion of the State.

Written notification of each failure to meet a performance requirement shall be given to the Contractor prior to assessing liquidated damages. The Contractor shall have five (5) business days from the date of receipt of written notification of a failure to correct the failure or submit a corrective action plan. The plan must be approved by KHPA. If the failure is not resolved within this warning/cure period, liquidated damages may be imposed retroactively to the date of failure to perform. Liquidated damages imposed under this RFP shall be cumulative. The imposition of liquidated damages is not in lieu of any other remedy available to the State. The Contract Manager will consider each deficiency on a case-by-case basis and may waive damages at KHPA's discretion. Such waiver will not prevent the State from assessing future damages if the failure recurs.

2. Deductions of Damages from Payments Due

KHPA may deduct amounts due as actual or liquidated damages from any monies payable to the Contractor pursuant to its contract. The Contract Manager shall notify the Contractor of any claim for damages. The State shall have the option to request payment for damages either through deduction from monies payable to the Contractor or remittance made by the Contractor, directly to the State.

T. PERFORMANCE GUARANTEES

	Requirement	Liquidated Damages
1	Failure to submit Project Plan: by the date as agreed upon by Contractor and KHPA per Section 4.5.1.A.1	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
2	Failure to conduct debtor/provider outreach: as required by Section 4.5.1.A.2	For each month (beginning 75 days after DOA) that the Contractor fails to conduct adequate debtor/provider outreach, damages of .1% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.

3	Contractor Organizational Chart: must be provided to the Contract Manager as required by 4.5.1.A.3	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
4	Meetings: must be conducted by the Contractor as in accordance with Section 4.5.1.B	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
5	Progress and Fiscal Reports: must be submitted to the Contract Manager or designee as stated in Section 4.5.1.C	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
6	Case File Maintenance: by the Contractor as found in section 4.5.1.E	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
7	Organizational Structure and Staffing: Contractor must staff a CMD and other professional medical staff as required by section 4.5.5.E	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
8	Medicaid Policy: for the purposes of the RAC portion of this RFP, the Contractor shall accept KHPA's interpretation of any Medicaid policy as stated in Section 4.5.2.3.B	For each instance in which the Contractor is non-compliant, damages of .02% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
9	Timeline to Complete Complex Review of Claims: the Contractor shall complete 99% of its complex reviews within the 100 calendar day window given in section 4.5.2.3.C.2.b	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
10	Meeting Summaries: Meeting summaries requirements and standards are found in Section 4.5.1.B	For each business day after the Contractor is notified of its non-compliance, damages of .02% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency

		payment.
11	Rationale for Determinations: The Contractor shall document its rationale for determinations for the RAC portion of this RFP as stated in section 4.5.2.3.D.1	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
12	Reopening of overpayments based only on failure of debtor/provider to submit documentation: Contractor shall reopen every RAC case in which a overpayment determination was based solely on failure of the debtor/provider to submit documentation within the timeline given and on which the provider later submits documentation or requests an appeal as stated in section 4.5.2.3.D.3.d	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
13	Notification of Overpayment/Debt: Contractor shall send the debtor/provider notification of the debt/overpayment prior to taking any collection action as stated in sections 4.5.5.A and 4.5.2.3.D.2	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
14	Turnover Plan: Deliverables and requirements are found in Section 4.5.5.Q.	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
15	Recoupment of Overpayments during an appeal: the Contractor shall not recoup or send claims to the fiscal agent for recoupment and overpayment determination that is being appealed as stated in section 4.5.2.5.G	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
16	Support during an Appeal: The Contractor shall provide support o KHPA or its sister agencies for an appeal of an overpayment determination as outlined in section 4.5.2.6	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
17	Projected Cost Recovery: The Contractor must comply with the projected cost recovery requirement of this RFP as stated in section 4.5.4.B	The Contract Manager shall apply liquidated damages to the Contractor in an amount equal to the difference between the projected recoveries minus 10% and the actual recoveries (e.g. projected recovery of \$100,000 and an actual recovery of \$50,000 would result in damages of \$40,000 $((100,000 * .1) - \$50,000)$). The damages shall be due and owing within five (5) business days from the date that the liquidated damages are applied by the Contract Manager.
18	Reporting of Potential Fraud: The Contractor shall report all instances of potential fraud to KHPA as required by section 4.5.5.D	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next

		contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
19	Recalled Cases: The Contractor shall not work on any case recalled by KHPA as stated in section 4.5.5.F	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
20	Customer Service: The Contractor shall comply with section 4.5.5.J	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
21	Quality Assurance: The Contractor shall comply with section 4.5.5.K	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
22	Business Continuity Plan: The Contractor shall submit a Business Continuity Plan and Risk Management Plan as outlined in section 4.5.5.N	For each business day after the Contractor is notified of its non-compliance, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
23	Fair Hearings: The Contractor shall comply with section 4.5.5.O	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
24	Grievances: The Contractor shall comply with section 4.5.5.P	For each instance in which the Contractor is non-compliant, damages of .01% will be assessed against the contractor's next contingency payment until such time as the deficiency is corrected by the Contractor. Damages will be deducted from the contractor's next contingency payment and any damages applied prior to recovery of money under this RFP shall be applied against the first contingency payment.
25	Real Damages: The Contractor shall be responsible to KHPA for any real damages caused by the Contractor's action or inaction in carrying out the responsibilities listed in this RFP.	

U. DISPUTE RESOLUTION

Notwithstanding the authority of the Director of the Division of Purchases (reference Section 3, paragraphs 5 and 6), any dispute arising under the contract which is not disposed of by agreement between the State and the Contractor will be decided by the KHPA Director of Medicaid Operations, who will commit his or her decision to writing and will serve a copy to the Contractor. The decision of the KHPA Director of Medicaid Operations shall be final and conclusive.

Pending final determination of any dispute hereunder, the Contractor will proceed diligently with the performance of the contract and in accordance with the direction of the KHPA Director of Medicaid Operations.

V. COST SHEET

The Cost Sheet attached hereto is to be completed and submitted separately from the technical proposal. Both documents must be identified as being in response to this RFP.

W. SUBJECT TO OPEN RECORDS ACT

Audits and all other materials generated by or under the contract, unless clearly marked by the Contractor as proprietary, will be subject to disclosure and disclosed, under the Kansas Open Records Act.

